

REQUEST FOR LABORATORY SERVICES

SHP CLINICAL LABORATORY

<p>Laboratory services are available at all SingHealth Polyclinics.</p> <p><input type="checkbox"/> SingHealth Polyclinics - Bedok 11 Bedok North Street 1 #03-01 Heartbeat @ Bedok Singapore 469662</p> <p><input type="checkbox"/> SingHealth Polyclinics - Bukit Merah Blk 163 Bukit Merah Central #04-3565 Singapore 150163</p> <p><input type="checkbox"/> SingHealth Polyclinics - Marine Parade Blk 80 Marine Parade Central #01-792 Singapore 044080</p> <p><input type="checkbox"/> SingHealth Polyclinics - Outram 3 Second Hospital Ave L2 Health Promotion Board Bldg Singapore 168937</p> <p><input type="checkbox"/> SingHealth Polyclinics - Pasir Ris 1 Pasir Ris Drive 4 #01-11 Singapore 519457</p> <p><input type="checkbox"/> SingHealth Polyclinics - Punggol Blk 681 Punggol Drive #02-01 Oasis Terraces Singapore 820681</p> <p><input type="checkbox"/> SingHealth Polyclinics - Sengkang 2 Sengkang Square #01-06 Sengkang Community Hub Singapore 545025</p> <p><input type="checkbox"/> SingHealth Polyclinics - Tampines 1 Tampines Street 41 Singapore 529203</p>	<p>Patient's Name : _____</p> <p>NRIC/FIN/PP/REG # : _____</p> <hr/> <p>D.O.B and Age : _____ Gender : _____ M / F</p> <p>Nationality : _____ Race : _____</p> <p>Mobile Number (Patient) : _____ Mobile Number (Next-of-kin) : _____</p> <p>Date of Request : _____</p> <p>Date/Time of Specimen Collection : _____ AM / PM Fasting Specimen : _____ Yes / No</p> <p>Requesting Physician's Name, MCR#, Signature and Contact Number : _____</p> <p style="text-align: center; font-size: small;">The contact number provided should be contactable (including after business hours) to enable our laboratory to inform the requesting physician or an assigned staff member of any test results that are in critical range.</p> <p>Clinic Name, Address Telephone Number & Fax Number : _____</p> <p>Brief Clinical History : _____</p>
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POLYCLINIC PATIENT

Test(s) requested: _____ (Please in boxes provided)

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|---|---|--|--|
| <input type="checkbox"/> Stool Occult Blood
<input type="checkbox"/> Stool Ova & Parasites
<input type="checkbox"/> Stool Culture
<input type="checkbox"/> Urine Culture | <input type="checkbox"/> HBsAg
<input type="checkbox"/> Anti-HBs
<input type="checkbox"/> Anti-HAV IgG
<input type="checkbox"/> Rubella IgG Ab
<input type="checkbox"/> Dengue NS1 Ag
<input type="checkbox"/> HIV Screen
<input type="checkbox"/> Hepatitis B Screen (HBsAg, anti-HBs or Anti-HBc IgM) | <input type="checkbox"/> ABO RH
<input type="checkbox"/> APTT/PT
<input type="checkbox"/> PT/INR
<input type="checkbox"/> Full Blood Count
<input type="checkbox"/> Blood Film Report
<input type="checkbox"/> Malarial Parasite, blood film
<input type="checkbox"/> Dipstick and Microscopic Exam, urine | <input type="checkbox"/> AFP, serum
<input type="checkbox"/> CEA, serum
<input type="checkbox"/> Glucose, capillary
<input type="checkbox"/> HBa1c, blood
<input type="checkbox"/> Uric Acid, serum
<input type="checkbox"/> Bilirubin, paediatric, serum
<input type="checkbox"/> hCG (Qualitative), urine
<input type="checkbox"/> Lipid Panel (CHO/HDL/TG/LDLc), serum
<input type="checkbox"/> Renal Panel (Ur/K/Na/Cl/Glu/Cre), serum
<input type="checkbox"/> Liver Panel (TP/ALB/TBIL/ALP/ALT/AST/GGT), serum
<input type="checkbox"/> Thyroid Panel (FT4/TSH), serum |
|---|---|--|--|

Others : _____ Remarks: _____

Conditions for Laboratory Test Services:

- 1 Laboratory Test Requests must be signed by the requesting physician and state
 - a) the requesting physician's name and contact number; and
 - b) the clinic's name, address, telephone number and fax number.

- 2 The requesting physician's contact number should enable our laboratory to contact the requesting physician or the assigned staff member even after business hours in the event that the laboratory test result is within the critical range.

- 3 The requesting physician or assigned staff member needs to be readily contactable to ensure that timely medical advice is provided to the patient. It shall not be the Laboratory's responsibility to liaise, on behalf of the requesting physician, with the patient for notification of and advice on the laboratory test results or clinical management.

- 4 We reserve the right to decline performing the tests in the absence of any information that we require as indicated in the "Request for Laboratory Services" form.

- 5 The requesting physician and the clinic shall hold harmless and indemnify Singapore Health Services Pte Ltd t/a SingHealth Polyclinics and its subcontractors and their respective agents, authorised representatives, directors and personnel against any claims arising from or in connection with inaccessibility of the requesting physician or any authorised staff to receive the test result(s) or failure by any of them to provide timely notification of the laboratory test result(s) and medical advice to the patient.